Site Applicability

BC Children's Hospital and BC Women's Hospital + Health Centre

Patient Population

- 2 months of age and greater, proxy observation tool
- For persons who are not able to self-report their pain or those with neurodevelopmental impairment.

Indication

- For use with acute, chronic, and/or complex pain
- For use in all patient care settings for patients who are non-verbal
- Revised FLACC relies on behavioural indicators to assess pain.
- Behavioural observation and parental report are the primary methods for assessing pain in non-verbal or cognitively impaired children.

Objectives

The Revised Faces, Legs, Arms, Crying, Consolability Scale (r-FLACC) is an observational pain tool based on the FLACC scale (1997) that has been revised to include additional pain behavior descriptors. These behaviour's are often found in children who are non-verbal or have developmental delay.

This tool is a checklist that guides the health-care professional in observing the child's behaviour in response to pain.

A pain tool provides a baseline and ongoing subjective measurement of a patient's pain intensity score over time, to inform decision making around the management of pain.

How to use the r-FLACC scale

1. Review with the family or caregivers, the descriptors within each category of the r-FLACC and educate them about its use.

2. Revise the r-FLACC as necessary by asking family or caregivers which additional behaviors are indicators of pain for their child.

3. Rate the child's behaviour on each of the five categories (face, legs, arms, crying, consolability). Each category is scored on the 0 to 2 scale.

4. Add the scores together (for a total possible score of 0 to 10).

5. Document the pain score in the health record as per unit procedures and guidelines.

In children who are awake: Observe for 1-5 minutes or longer. Observe legs and body uncovered. Reposition child or observe activity. Assess body for tenseness and tone. Console the child if needed.

In children who are asleep: Observe for 5 minutes or longer. Observe body and legs uncovered. If possible, reposition the child. Assess the body for tenseness and tone.

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Pain Assessment Tool

(REVISED) FLACC Scale SCORING			
Categories	**0**	**1**	**2**
Face	No particular expression or smile.	Occasional grimace or frown, withdrawn, disinterested, **Sad, appears worried.**	Frequent to constant quivering chin, clenched jaw, **distressed looking face, expression of fright/ panic.**
Legs	Normal position or relaxed; **usual tone and motion to limbs.**	Uneasy, restless, tense, **occasional tremors.**	Kicking, or legs drawn up, **marked increase in spasticity, constant tremors, jerking.**
Activity	Lying quietly, normal position, moves easily, **regular, rhythmic respirations.**	Squirming, shifting back and forth, tense, **tense/guarded movements, mildly agitated, shallow/ splinting respirations, intermittent sighs**	Arched, rigid or jerking, **severe agitation, head banging, shivering, breath holding, gasping, severe splinting.**
Cry	No cry (awake or asleep)	Moans or whimpers: occasional complaint, **occasional verbal outbursts, constant grunting**	Crying steadily, screams or sobs, frequent complaints, **repeated outbursts, constant grunting.**
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to: distractible	Difficult to console or comfort, **pushing caregiver away, resisting care or comfort measures.**
Each of the five categories (**F**) Face; (**L**) Legs; (**A**) Activity; (**C**) Cry; (**C**) Consolability is scored from 0-2, which results in a total score between zero and ten.			

References:
Merkel, S. et al. The FLACC: A Behavioural Scale for Scoring Postoperative Pain in Young Children, Pediatric Nurse 23(3): 293-297, 1997. Copyright: Jannetti Co. University of Michigan Medical Centre.

Malviya, S., Vopel-Lewis, T. Burke, Merkel, S., Tait, A.R. (2006). The revised FLACC Observational Pain Tool: Improved Reliability and Validity for Pain Assessment in Children with Cognitive Impairment. (Pediatric Anesthesia 16: 258-265).

Interpreting the score

0 =	Relaxed and comfortable
1–3 =	Mild discomfort
4–6 =	Moderate pain
7–10 =	Severe pain or discomfort or both

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Documents

- Pain and Comfort Policy
- Pain Assessment Standard

Appendix

Revised Faces, Legs, Arms, Crying, Consolability Scale (r-FLACC)

References

Anderson RD, Langlus-Eklof A, Nakstad B, Bernkley T & Jyll, L. (2017). The measurement properties of pediatric observational pain scales: a systematic review. International Journal of Nursing Studies. 73, 93-101.

Chen-Lim, M. L., Zarnowsky, C., Green, R., Shaffer, S., Holtzer, B., & Ely, E. (2012). Optimizing the assessment of pain in children who are cognitively impaired through the quality improvement process. *Journal of pediatric nursing*, *27*(6), 750-759.

Crelin, DJ, Harrison D, Santamaria N & Babl FE (2015). Systematic review of the Face, Legs, Activity, Cry, and Consolability scale for assessing pain in infants and children: is it reliable, valid, and feasible for use? Pain 156 2132-2151.

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Von Baeyer, C. L., & Spagrud, L. J. (2007). Systematic review of observational (behavioural) measures of pain for children and adolescents aged 3 to 18 years. *Pain*, *127*(1-2), 140-150.

Developed By

C&W ChildKind Project

Version History

DATE	DOCUMENT NUMBER and TITLE	ACTION TAKEN
02-Feb-2021	C-0506-14-60957 Revised Faces, Legs, Arms, Crying, Consolability Scale	Approved at: C&W Best Practice Committee

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APPENDIX A:

Revised Faces, Legs, Arms, Crying, Consolability Scale (r-FLACC) - PAIN TOOL

Categories	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested, **sad, appears worried**	Frequent to constant quivering chin, clenched jaw, **distressed looking face, expression of fright/panic**
Legs	Normal position or relaxed, **usual tone & motion to limbs**	Uneasy, restless, tense, **occasional tremors**	Kicking, or legs drawn up, **marked increase in spasticity, constant tremors, jerking**
Activity	Lying quietly, normal position, moves easily, **regular, rhythmic respirations**	Squirming, shifting back and forth, tense, **tense/guarded movements, mildly agitated, shallow/splinting respirations, intermittent sighs**	Arched, rigid or jerking, **severe agitation, head banging, shivering, breath holding, gasping, severe splinting**
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